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An Address*

Delivered by
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Brisbane.

On the occasion of the annual meeting of the Branch, it is the privilege of the retiring President to deliver an address. No one can regret more than I that our genial President (Dr. Alex. Marks) is not with us for that purpose to-night. He, as you know, is taking an active part in the defence of our Empire, and we may congratulate the soldiers who are under his care upon having a medical attendant whose skill and robust kindliness must be a considerable element in the advancement of their welfare and general comfort.

It is perhaps presumptuous of me, at the beginning of my year of office, to address you, but, when considering the arrangements for to-night, I felt that some such procedure as that which is customary at our annual meetings should be followed. I have, therefore, written some odds and ends which I trust may prove of interest to you.

Daylight Saving.

First I wish to urge the desirableness of an effort being made by the Branches of the British Medical Association in the direction of the adoption by Parliament of some means for the better use of the early hours of our summer days. You will all know what is meant by a Daylight Saving Bill. Briefly, it is this. On a selected day, say the last day of August, at some time between 8 p.m. and midnight, every watch and clock in the Commonwealth would be advanced by two hours. So that on the following morning everyone's day would begin two hours earlier than usual, and all the routine of the day would be advanced by two hours. So, for instance, breakfast might be at 6 instead of at 8, lunch at 11 instead of at 1, dinner at 4 instead of at 6, bed at 8 instead of at 10. Our morning rounds would be finished at 9 and our afternoon rounds would begin at 1, our evening hours being over at 5.30 or 6. How great the advantage of such an arrangement as this would be to the whole community it is difficult to compute, without having put the plan to the test of experience, but it does not seem to me that there could be any harm done. At least, we should have the use of about 60 hours of daylight in each summer month and pay for so much less of artificial light. On the last day of April the clocks would be put back two hours, and winter conditions assumed. I do not propose to enumerate the advantages which would be secured to us by the adoption of this arrangement, but surely no one of us who has had an early summer morning call can have failed to deplore the habitual waste of the invigorating and beautiful early hours of daylight. For the working man and woman, of other occupations than ours, the advantages would be equally great. The youth who has occupied a cramped seat in a hot office during his allotted hours of clerkship would be free at 2.30 instead of at 4.30, or at 4 instead of at 6; the factory girl would leave her bench at 3 or 4 instead of at 5 or 6, with the prospect of spending some hours of daylight in an occupation more healthful than doing the block under the light of the city gas-lamps. Most impressive, perhaps, of all, our children would begin school at 7.30 and leave at 1 or half past; and for those who had home-work, there would be no necessity for the use of lamps or gas. On Saturdays the majority of working people would be off duty at 10, with the remaining hours of the day for pleasure and recreation. The more one thinks of such a plan the more desirable it seems to be. So far as I can see, the chief initial difficulty in connexion with its adoption would be in regard to railways—for it must be remembered that the time-tables would not need to be altered at all—but I think that in a couple of days it would be found that the trains were running to time again. No doubt many of you have given more than a passing thought to the question of a Daylight Saving Bill, and I think, if the health and well-being of the community are to be served by such a measure, that the medical profession should endeavour to induce our legislators to introduce a Bill with that object at some time during the early part of next year, in order that the suggestion might be put to a practical test during the summer of 1915-16.

Gastro-Enteritis of Infants.

I wish to take advantage of this opportunity to say something about summer diarrhœa or gastro-enteritis of children. One always encounters a number of these cases in the early summer, and this year I have had to treat more than usual. They are fascinating cases to treat, and demand much careful attention and intelligent change of treatment. It seems to me that summer diarrhœa can be prevented, or at least that its seriousness can be reduced, if parents are forewarned of its dangers, and forearmed with a plan for its prevention.

On the occasion of my last visit to a woman whose confinement I have attended, I exact a promise from her that she will give her baby nothing but breast milk without consulting me, that she will bring the baby to see me on or about a certain date, which I fix there and then (and which the mother never forgets), and I tell her that my fee for attendance upon her at her confinement includes attendance upon her baby at my consulting room until it is one year old. When the child is brought to me, generally at about four months, I fix a date for the next visit, and so on. Even if the mother has a plentiful supply of milk, I advise that at least one

*Read at the annual meeting of the Queensland Branch of the British Medical Association on December 11, 1914.

meal of cow's milk be given to the baby when it is as young as four months, if that age is reached during the months of May to August. If the child reaches the age of four months in September, October, or November, I insist upon every effort being made to continue breast-feeding—and breast-feeding only—until April. The reason for this is that I have found, as you have all found, that a baby who may be killed by cow's milk in October and November, will thrive upon it in June and July, and I am convinced that a child who is broken in to drinking cow's milk during the winter months will not experience any difficulty with that form of diet in the early summer. In short, wean a baby in the winter and it will thrive in the summer. In the original draft of my paper I have inserted here some remarks upon the diet of children generally, but I will save your patience by saying that a war should be waged with all the emphasis of which we are capable, against the pernicious habit of feeding children upon biscuits.

With regard to the actual treatment of a case of summer diarrhœa, I have nothing new to say. The child should be nursed in its mother's arms all the time, or at least all the time that it is awake. I begin medicinal treatment with a dose of castor oil, followed by about six powders containing bismuth, pulv. ipecac. co. and calomel, and then by a mixture containing magnesium sulphate, given alternately every four hours with a mixture containing tincture of iodine. Starvation, water, albumin water and whey are employed until the tongue is clean; then bread and butter, and after that, more bread and butter, if the child has reached the bread and butter age.

The European War.

I cannot escape the necessity of a reference to the terrible war which is devastating Europe.

We have been taught to subdue the instincts which we have inherited from our fighting forefathers, and, with occasional relapses, we have learnt, at least, to control them; now we find ourselves breathing horrific aspiration, and expressing barbaric sentiments against a nation which we had regarded as being in the forefront of scientific progress. Nor can our present attitude be wondered at when we read of the atrocious deeds of the murdering hosts let loose upon unoffending pacific nations. The criminal vanity of one man, exercising a mediæval tyranny, and obsessed with the blasphemous delusion that he is of divine kinship with the God of the Old Testament, has plunged the world —without cause and without excuse—into a chaos of bestial and unutterable carnage. The end is not yet, nor can one foretell the end; though, with an intuition which can hardly be at fault, one feels that the final victory must be to the cause of freedom, of justice, and of honour.

We, if we had our wish, would be at the front, ministering to the needs of the wounded and the dying, trying to give our help to the Mother Country where help appears to be most required. But we cannot all go, and those of us who are left unwillingly behind have still our duties to perform, duties less stern, but as necessary as those which are being nobly performed by our colleagues at the front. That they will uphold the great traditions of our noble profession we are assured, and that they may return to us in victory and with great honour we do most fervently hope. God Save the King!

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A FEW REMARKS ON VACCINE THERAPY.*

By **W. Sidney Page, M.R.C.S., L.R.C.P. (Eng.), M.B., B.S. (Lond.).**

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I have been asked to make a few remarks to you to-night on a subject in which I am interested, namely, vaccine therapy, to discuss its limitations, and to endeavour to explain the reasons why we sometimes fail to effect a cure, or at least a marked improvement in the condition of the patient. For many years now we have been familiar with the use of anti-toxin and of anti-sera, but it is only during the last few years that vaccines have been so extensively used. Both aim at procuring immunity, but do so in a different way. I think it would not be amiss at this point to say a few words about immunity. We do not understand how immunity is actually produced, and our explanations of it are theoretical, but nevertheless we recognize several kinds of immunity which are no doubt familiar to you. What is immunity? Immunity is the power which some of us possess of resisting the attack or rather evil consequences of the attack of something which will do harm to others. This "something" may be an infectious disease, any poisons, nicotine, alcohol, drugs, etc. We may recognize the following forms of immunity: Natural immunity, inherited; acquired immunity (naturally or artificially). Natural inherited immunity is that which an individual possesses because it belongs to a given species, e.g., lower animals are immune to the gonococcus, and many of them to the spirochæta pallida, and there are many diseases which affect animals against which we are immune, e.g., distemper. Naturally acquired immunity is that form of immunity which an individual possesses after having survived an attack of some disease. We are familiar with this form of immunity after such illnesses as smallpox, measles, scarlet fever, and other infectious diseases. This immunity is specific. The cells of the body having resisted the attack of the micro-organisms and their toxins by their own efforts, have acquired some property with which they are able to ward off further attacks.

Artificially acquired immunity may be active or passive.

Active acquired immunity may be produced by the intentional induction of the disease, as in the old days when people were inoculated against small-pox directly from a patient suffering with that disease. This method, however, of producing active immunity is no longer used on the human race, though still largely made use of in veterinary work, e.g., in Texas fever, pleuro-pneumonia of cattle, etc. It

* Read before a meeting of the Queensland Branch of the British Medical Association on November 6, 1914.

may also be acquired by the inoculation of live virulent micro-organisms, of attenuated micro-organisms, and lastly of dead micro-organisms, e.g., anthrax, rabies, etc.

Passive immunity is that form of immunity which is given to an individual by the injection of the serum of some animal that has been actively immunized. The defensive properties have been manufactured by the cells and tissues of this animal. In the case of anti-diphtheritic serum, which is so largely used, the passive immunity conveyed to the patient receiving it is due to the antibodies formed in the horse's serum during the process of active immunization against diphtheria toxin.

It is of the active artificially acquired immunity that I wish to speak principally, and of that form produced by the inoculation of dead micro-organisms, since there is considerable danger in the inoculation of live virulent or attenuated microbes in the subject.

It is in the skilful use of dead micro-organisms in the production of active immunity that a new chapter of medicine has been opened, and that the world owes so much to Sir A. E. Wright. This does not mean that Sir A. E. Wright was the first in the field to endeavour to procure active immunization by inoculation. Pasteur, some years before, immunized sheep by the use of an attenuated strain of anthrax bacilli; and Haffkine, in India, had obtained good results by inoculation of living virulent cholera germs.

Wright, however, was the first to bring the use of vaccines, that is dead micro-organisms, into the realm of modern therapeutics, and although the results of the first attempt of prophylactic inoculation on a large scale (anti-typhoid inoculation, Boer War, 1898-1900) were conflicting and not regarded by many competent observers as satisfactory, it has since been proved that it was the technique of the preparation of the vaccine in large quantities that was faulty, and not the principles of the treatment (Harben Lectures, 1910, Anti-typhoid Inoculation by Lieut.-Col. Sir William Leishman, R.A.M.C.). That an individual can be actively immunized against typhoid fever for a period of at least two years, has been abundantly proved by the statistics available as regards the inoculation of the armies of the great powers. In the South African war there were 57,000 cases of enteric fever, with 8,000 deaths, and a great many of these cases had been inoculated against enteric fever. So the results in those early days of inoculation were not encouraging. However, in the enquiry that was held after the war into the efficacy of anti-typhoid inoculation, it was found that much of the vaccine used conveyed little or no immunizing power at all, the reason being faulty technique in its preparation. Further research and experiments, however, produced a vaccine from the laboratories, R.A.M. College, Netley, where Sir A. E. Wright was formerly Professor of Pathology, and this is the vaccine which is practically used by all the great Powers. Anti-typhoid inoculation is unfortunately not compulsory in the British Army, but Tommy Atkins in India is well aware of the risks he runs, and of the heavy death rate from enteric fever that has been present for many years. It is pleasant reading to learn that of the men in the British garrison in India 93 per cent. have been inoculated, and that the number of deaths has been reduced from several hundred per annum to about 20. The United States Army has a still more wonderful record. Anti-typhoid inoculation is compulsory, and amongst 90,000 troops last year there were only three cases of enteric fever, and no deaths. In the great struggle now going on, the advent of any outbreak of cholera, dysentery, small-pox, and enteric fever in Western Europe is being anxiously watched, and it seems a satire on our boasted civilization when we learn that the Turk on his enrolment as a soldier is compulsorily vaccinated against smallpox, inoculated against typhoid fever, and also against cholera. One sincerely hopes that none of our men have left these shores before they have been vaccinated and received a prophylactic injection against typhoid fever. A vaccine simply consists of a number of dead micro-organisms. They have been killed by heating at a certain temperature for a certain time, and then put into some preservative fluid, such as 0.5 per cent. carbol salt. The emulsion of bacteria should be well shaken, in order that the colonies may be broken up. Sterile glass beads help to do this expeditiously, and then the bacteria are killed by heating them for an hour in a water bath at a temperature of 56° C. Some of the vaccine should be tested on suitable media before being used, to ensure its sterility. The dose to be given varies of course with the nature of the vaccine, and the patient's age. For instance, in anti-typhoid inoculation, it is generally given in two stages. The first dose is one of 500 million dead typhoid bacilli. It really makes very little difference as to the site of inoculation. This injection nearly always causes a certain amount of reaction within the next 24 hours. It varies a great deal with the susceptibility of the patient, a feeling of malaise, headache, and a rise of temperature to 101° F. or 102° F. is often experienced. The next dose of 1,000 million is given a week or ten days later, and as a rule there is very little reaction. The doses of other vaccines depend on their nature and virulence.

The use of vaccine in bringing about active immunization when used in a scientific manner has brought before the medical profession a new branch of study, which is called vaccine therapy. The rationale of the treatment consists of cultivating on artificial media the bacteria that are causing the disease, and injecting their dead bodies. This calls forth the production by the cells and tissues of the organism of anti-bacterial substances, which increase the immunizing response of the subject, and help to overcome the microbic invasion wherever it may be. In Wright's words, the principle of vaccine therapy is "to exploit in the interest of the infected tissues the unexercised immunizing capacity of the uninfected tissues." Coming to the practical application of vaccine therapy, theoretically every disease that is of known microbic origin, and the germs can be isolated and cultivated, should be amenable to vaccine treatment. A great many are, especially those

in which we can isolate the offending organisms in pure culture. But mixed infections are much more our lot, and increase our difficulty tenfold. An early case of gonorrhœa does very well with a vaccine, and an early case of pulmonary tuberculosis does well under tuberculin, but when you get a mixed infection in these cases it must be treated with a suitable vaccine before you will do much good. The great majority of cases of pulmonary tuberculosis that we meet with are mixed infections, that is not only have we to deal with the tubercle bacillus, but with other organisms as well. Tuberculin treatment does not show such good results in these cases unless the mixed infection is dealt with. Many practitioners have given up the use of tuberculin in pulmonary cases on account of poor results. The cases frequently get worse instead of better. This is not the fault of the tuberculin, but due to the want of knowledge on the part of the medical man as to the skilful administration of tuberculin. Tuberculin is unquestionably of great help in the treatment of pulmonary tuberculosis, provided that the patient is carefully watched, the dosage controlled, and secondary organisms dealt with. Febrile cases with much expectoration and trying cough, night sweats, the usual picture of phthisical cases in a mixed infection (and most often a streptococcal or pneumococcal one) improve in a wonderful manner when this is attended to before beginning tuberculin treatment. For some years now I have been using Koch's B E with very good results, starting with very small doses, about 1/250,000 milligramme. It consists of a suspension of dried and ground up bacilli in equal parts of glycerine and water. I do not think opsonic control is necessary, provided one has the patient under one's own personal supervision. Good results are obtained by tuberculin in joints, bladder, and kidney cases. In the treatment of tuberculous glands it should always be tried before recourse is taken to surgery. The process may be slow, but it is sure. I had a lady under my care, the whole of the anterior and posterior triangles of the left side of the neck was a mass of tuberculous glands. The reaction to von Pirquet's test was intense. Starting with 1/250,000 milligramme of Koch's B E, and giving an injection only once a week, the treatment extended over nine months before nearly all the glands had disappeared. Some of the larger ones in the submaxillary region were still palpable, but I considered them so sclerosed as to be harmless, and none were visible to the naked eye. This patient was so susceptible to tuberculin that after three months' treatment an injudicious rise in dosage sent her to bed with a temperature of 103° F., and I never got beyond a dose of 1/50,000 milligramme. There has been no recurrence now for over two years. From a diagnostic point of view, tuberculin is of great value, but results have to be read with great care. Calmette's test, the instillation into the eye of a small quantity of old tuberculin, is a very delicate and accurate one, but it is not generally used, as sometimes severe conjunctivitis is set up, and cases have been reported in which even the eye has been lost. The cutaneous test of von Pirquet is not of much value in any one over the age of 7 years—a positive result may be obtained in a patient who had a tuburcular lesion years ago, which had become quiescent. It does not discriminate between an active and healed lesion, but it is of great value as a test in children. The subcutaneous injection of old tuberculin is the most reliable. The patient's temperature should be taken every four hours for some three or four days before to make sure that there is no continued fever. A rise of a degree or a degree and a half within 24 hours after the injection may be regarded as a sign that tuberculosis is present. A patient I saw for Dr. Buchanan some little time ago gave a typically positive reaction to this test; it was a question as to whether there was tubercular disease of the urinary tract or not. Tubercle bacilli were not to be detected in the urine after many examinations, and some of the pus from the centrifugalized urine had no ill effects on inoculating a guinea-pig. This patient did well on tuberculin treatment, rapidly gained weight, and has been back at work some time.

There has been a great deal of correspondence lately in the "Lancet" between well-known medical men about oral sepsis. It is only within the last decade that so much attention has been paid to this condition, and to its existence almost every illness that mortal being can suffer has been attributed. All sorts of anæmias, rheumatic manifestations, lumbago, sciatica and even appendicitis have been mentioned. That many a patient has been rendered edentulous on account of some pyorrhœa alveolaris appears only too evident from the correspondence. Unquestionably pyorrhœa alveolaris is the cause of many setbacks to the general welfare of the patient, but it wants to be very bad before all the teeth need be removed. That this condition is extremely prevalent in cases of anæmia, rheumatism, indigestion, malnutrition, is correct, and it is also true that they improve rapidly as a result of treatment. If the teeth are loose in their sockets the alveolar processes are largely involved, the bone necrosed, and the roots bare, extraction is the only thing, and even then the local disease of the bone may remain. This, however, is a very late state in the disease. Some months ago a lady was sent to me for this trouble who had been under a dentist for some time. He proposed the extraction of the front teeth in the upper and lower jaw. She was anæmic, lost her appetite and energy, as well as weight, and had vague rheumatic pains. One or two of her teeth were just beginning to loosen, and on pressure some pus exuded from the pockets around the teeth. An autogenous vaccine was made, consisting of a streptococcus, and in a month or two the improvement was marked. She ate well, put on weight, and as she herself stated, was a different being. Within six months she had gained over a stone, the pyorrhœa had disappeared, and the teeth were no longer moveable in their sockets. Another patient that was sent to me by Dr. Ahern, a girl aged 12 years, came on crutches; her right hip had been crippled, apparently from rheumatoid arthritis. She had been in the Prince Alfred Hospital in Sydney for some time, and also at the Children's Hospital in Brisbane. She had some pyorrhœa. A vaccine was

made, a streptococcus being isolated. Within four weeks this girl was able to do without her crutches, and to do housework for her mother. She was treated for three months, after which I did not see anything of her for some time. The next time she appeared she had her right arm in a sling, the right elbow joint being affected. This cleared up in the course of two or three injections, and the last time I saw her she was perfectly well in all respects. In ordinary staphylococcal infections such as boils, carbuncles, etc., we must admit the efficiency of vaccine treatment, even stock vaccines being of great use. It occasionally happens in midwifery practice that we have cases that do not do well. We know, or at least should know, that nearly all cases of puerperal fever are fatal. I admit it is hard to tell cases of sapræmia from septicaemia in its early stages by clinical signs alone. Those who adopt the expectant treatment after having curetted the uterus, very often call in the bacteriologist to make a blood culture when the patient is comatose. I think that every medical man who has a patient after parturition, who has persistent fever for some days, after he has made sure there is no retention of any membranes or placental tissue, is not doing his best for her unless a blood culture is made. If it is negative all the better for the patient, but if it is positive then an autogenous vaccine can be made. According to Western's figures, based on 100 cases of puerperal fever, the mortality is reduced from 98 per cent. to 50 per cent. by the early use of autogenous vaccines. American observers have had almost similar figures. Quite lately I was called in by two medical men to see a patient who had been ill over a fortnight. It was not her first child. The infant was born at full time, and all went well, except that the placenta was got away with some little difficulty. Her temperature had been as high as 104° and 105° F., and this was associated with rigors. She had been curetted. When I saw her she was comatose, and she died within 24 hours. A blood culture was made, and showed that the blood was teeming with streptococci. The patient would have had a fair chance if one had been called in a week or ten days earlier. Dr. Spark asked me to see a case for him at the Mater Hospital a few weeks ago. Clinically it was a case of septicæmia. To my surprise my cultures were negative. I was out of town for some weeks, and on my return was very surprised to learn that the patient was well. An abscess had formed somewhere in the broad ligament, and after surgical treatment had been applied she got well. It was a case of sapræmia; if it had been septicæmia my cultures would not have been negative, and an autogenous vaccine could have been prepared. It would take me too long to quote my successes in vaccine therapy, and also my failures, but you must remember that nearly all our successes and failures, especially in chronic cases, have been previously under medical treatment for some time without any satisfactory result. There is no doubt that a dose of mixed vaccine, say of pneumococcus and catarrhalis will often abort a cold. I admit the immunity does not last long. We know that from personal experience, otherwise we should not always be getting colds. But I do not think that brother professionals would come to me again and again for an injection when they feel a cold coming on unless they knew it was of some use. In treatment the vaccine therapist only hopes that by increasing the immunizing power of his patient he will be able to beat off his enemy. In bronchial and asthmatic cases we would like him to have his nose, nasal-pharynx, and throat seen to lest the trouble be of reflex origin. Likewise in suppurating cases, pus must be evacuated, and dead bone removed, while in cystitis the possibility of a stone being present must be excluded. Staphylococci in the urine often suggest the possibility of a stone in the kidney or bladder, and streptococci puts the practitioner on his guard against tubercle.

In acne vulgaris, whether it is caused by the acne bacillus or staphylococcus (Saboraud says that comedone alone are caused by the acne bacillus, and pustulation is caused by staphylococcal infection), the results of vaccine treatment are on the whole good, though in very chronic cases with a good deal of scar tissue progress is very slow.

As regards stock vaccines on the market, the acne, staphylococcal, and gonococcal give the best results, pneumococcal and catarrhalis yield fair results, but those obtained by streptococcal and coliform vaccines are not good. Sensitized vaccines are now on the market. Besredka was the first to exploit these more than 10 years ago with typhoid bacilli. The bacillus was sensitized by an immune serum, and subsequently freed from excess of serum by repeated washing and centrifugalization. The bacilli are supposed to absorb certain protective substances from the serum, and produce a high degree of immunity in a very short time, and with very little reaction.

This sensitized vaccine has not been used on the French troops, probably on account of the difficulties in preparing it in large quantities, and ensuring its sterility. The French troops have been inoculated with a polyvalent vaccine, the strains being obtained from France, Morocco and Tunis. My own experience of sensitized vaccines so far has not led me to find any great advantage over the ordinary vaccine, and a good deal more time is needed in its preparation. I might say a few words here about phylacogen, which I suppose might be termed a modified vaccine, and is extensively advertised. There are no dead bacteria in phylacogen; it consists of a sterile solution of the toxins generated by bacteria grown on artificial media. In the use of mixed phylacogens, there is no need of a diagnosis of the specific offending organisms; it is very polyvalent, consisting of an aqueous solution of the toxins of most of the germs we know of. If, however, you are sure of your diagnosis, say for instance a case of gonorrhœa, then you use gonorrhœal phylacogen, which consists of a filtrate of a culture of gonococcus added to an equal amount of mixed phylacogen. I may add that mixed phylacogen is obtained from the culture of the following pathogenic bacteria: Staphylococcus (aureus, albus, citreus), streptococcus, pyocyaneus bacillus, pyocyanins-pneumococcus, bacillus typhosus, bacillus coli communis, bacillus diphtheriæ, streptococcus rheumaticus and strepto-

coccus erysipelatis. That the patient being treated with gonorrhœal phylacogen is certainly getting something for his money we must admit, and at the same time he is being actively immunized against most other diseases.

It certainly makes vaccine therapy very easy.

In intestinal toxæmia (before short circuiting is carried out), a vaccine often produces happy results. The offending organism may be isolated by plateing out some fæces and testing the patient's serum to its agglutinating powers. The bacterium that agglutinates best is the one chosen, and I have had very good results in these cases.

Many failures in vaccine therapy are due to incorrect bacteriological diagnosis. In chronic respiratory cases, there are many organisms present, the wrong bacterium may be selected, and it may only be after much work that the right one is used. It may not be possible to make the correct bacteriological diagnosis, and several vaccines may have to be tried. Again, the dose may be too small, the immunizing response is not sufficient, or if it be too large, we may be exhausting the immunizing power of the patient. The patient should be carefully watched, and the dose should not produce any more than a slight reaction. The general condition of the patient should also be looked after, especially as regards indigestion, constipation and action of the kidneys. The removal of foreign bodies, sequestra, etc., should be attended to. The use of Wright's fluid (5% sodium citrate in sodium chloride solution) prevents coagulation, and increases the flow of lymph to the part, and is of great help in suppurative conditions.

Still, we must admit there are failures for reasons unknown; it may be the patients are not capable of any immunizing response, or that we have still a good deal to learn about immunity. I think the latter is right. That vaccine therapy has an enormous future before it I have not the slightest doubt, and I am sure that most of our ills and woes will be effectively overcome by this means of active immunization.

Reports of Cases.

SYPHILIS AND CONGENITAL SYPHILIS OF THE LUNG.

By **Leonard W. Bickle, F.R.C.S. (Edin.),**

late Hon. Surgeon Adelaide Hospital, Adelaide, S.A.

In the "Medical Record" of August 22, 1914, Joseph Blinder reported a case of syphilis of the lungs. In this case the symptoms were those of phthisis, but examination of the sputum failed to reveal the presence of tubercle bacilli. A positive Wassermann reaction, the history of a chancre on the lip, and an enlargement of the liver, apparently gummatous, led to the diagnosis of syphilis, and a rapid cure followed the administration of anti-syphilitic remedies. When clerking for the late Dr. Stone, Physician to St. Thomas's Hospital, London, in 1879, I well remember the importance he laid of giving a trial of the biniodide of mercury with an excess of iodide of potassium in all cases of apparent phthisis of the lungs. This was about the time of the discovery of the tubercle bacillus, and the routine examination of the sputum for the bacilli was by no means a general procedure; the Wassermann reaction was unknown. Anyway, there were occasional cases where great benefit followed. These were probably cases which were purely syphilitic, or where a syphilitic infection was aggravating a tubercular condition.

In obscure lung cases in young people the possibility of congenital syphilis of the lung must be borne in mind. The condition is not by any means a common one, and in the course of practice extending over 33 years I can only recollect two cases in which I diagnosed the condition clinically. Both cases, too, simulated hydatid of the lung, so much that X-ray photographs were taken in each case, and in both the base of the left lung was found to be involved. The patient in each case was a girl.

Case I.—Some years ago a gentleman brought his daughter to see me. She was suffering from weakness of the spine and general ill-health. The symptoms had been ascribed by another medical man to hysteria. The father told me voluntarily that he had had syphilis badly in his younger days, and that the effects had been evident in some members of his family. Examination of the patient revealed definite spinal mischief. She was treated with rest and a poro-plastic spinal jacket. Internally I gave her the following prescription: R. Liq. hydrarg. perchlor. min. 30; Pot. iodid., gr. 10; Ext. glycyrrh, liq., min. 10; aquam ad. oz. ½, ter in die, and later ordered the syrup of the iodide of iron. She recovered without abscess formation, but there was some deformity of spine and a slight limp.

Some 3 or 4 years later she was again brought to me, this time for lung trouble. There was a history of some loss of flesh, irritant cough with slight expectoration, and apparently pleuritic pain in the left side. Examination revealed dulness over portion of the left base, with diminution of the breath sounds; no displacement of the heart, no œgophony, but a puzzling variation in vocal fremitus. No tubercle bacilli were found in the sputum. The peculiar shape of the dull area, which also varied somewhat, suggested the possibilities of a hydatid. I got Dr. Newland to take a radiogram for me; the result was practically negative. There were no signs suggestive of either tubercle or hydatid. Recollecting her previous history I put her on anti-syphilitic treatment, to which the system rapidly responded with so successful a result that she was soon able to resume her singing, which her illness had completely stopped. She has remained in excellent health ever since, and enjoys a considerable reputation as a singer.

Case II.—Between 18 months and 2 years since a young girl of between 13 and 14 years of age was brought to me. She was somewhat anæmic, tired very easily, and had lost her girlish activity and gaiety. There was a history of cough of some duration, but not much expectoration. She had got much thinner. Physical examination revealed some dulness over the left apex and some prolonged expiration, but no moist sounds. These signs varied somewhat. On some days they were not noticeable. She began to complain of obscure pain in the left side of her back and chest, Nothing definite could be heard on auscultation, and there was no appreciable difference in resonance between the two sides. No tubercle bacilli were found in the sputum. Later a variable dulness in the left side was obtainable, but the signs of fluid were not definite enough to justify the use of an exploring syringe. The question of hydatid was broached, and the taking of an X-ray photograph was agreed to by her friends. Dr. Newland took this for me; like myself he was puzzled by the erratic dulness. The radiogram did not assist in clearing up the diagnosis. When next I was examining her the light falling on the left cornea attracted my attention. A close examination revealed some old corneal trouble not ordinarily noticeable, and a careful enquiry gave a history of undoubted interstitial keratitis when she was a young child. This suggested a clue to the lung condition. Anti-syphilitc remedies were given, and all the symptoms rapidly cleared up. When seen a short while since she was the picture of health, ruddy in complexion, and plump, and full of girlish vivacity.

Personal.

During Dr. White's absence at the front, Dr. Anderson, of Adelaide Street, Fremantle, will carry on his practice.

Dr. F. Glynn Connolly has resumed practice at London Bank Chambers, Creek Street, Brisbane.

Dr. J. C. B. Lind has removed from Coopernook, New South Wales, to Franklin Terrace, West Croydon, South Australia.

Medical Journal of Australia.

SATURDAY, DECEMBER 26, 1914.

1914.

A general and useful precedent exists in medical as well as other journals of summarizing the achievements and advances registered during the year in the ultimate issue. The existing conditions impel us to depart from this precedent of publishing a retrospect of 1914 for two reasons. The "Medical Journal of Australia" first saw light in July, and was just beginning to chronicle the events of medicine when our Empire was roughly plunged into the most disastrous and the most unpardonable war the world has ever experienced. The effect of the war has made itself evident in all corners of the earth and in every congregation of individuals. The medical and other scientific publications of countries other than Great Britain and her colonies and America have been suddenly cut off. Clinical and laboratory work has been checked to an unusual degree, and the greater part of the energies and attention of the workers in the various branches of medicine have been turned to the consequences of the war. Under these circumstances the history of the past five months in so far as medical science is concerned has yet to be collated and written, and it were rash to anticipate such a record by attempting to register what has been attempted and what has been done.

The members of the medical profession are human, and while every member of the British Medical Association must feel a loathing for the military party in Prussia for having forced upon our country and its own a bloody carnage of immeasurable magnitude, and for having compelled us to sink our endeavours to move along the road to civilization, in our anxiety to free the world from a savage rule of steel, every medical man and woman cannot entirely forget the precept that science knows no nation, and is truly international in its essence. There is no such thing as British, French, Italian or German science, and a retrospect must search the annals of all countries for truth. We are not in the temper, even if it were possible, to speak of what has been done in the various countries in the great endeavour to save suffering, to prolong life and to improve the physical well-being of the human race. The latter months of 1914 have brought us much farther from our goal. But a short time since hygienists were congratulating themselves on the fact that the death-rate from preventable disease was being appreciably reduced in all cultured lands; to-day we have to acquiesce to the wasteful sacrifice of healthy men to stem a tide of man's own passions. Medical men are trained to retain a perfect self-control even when faced with the most pathetic tragedies imaginable; but it becomes pardonable if that self-control is not maintained when murderous weapons of modern warfare are deliberately employed to create the most horrible of all tragedies. The chronicle of the past few months must be reserved for a time, when these conditions are happily past, and when measures have been taken to render their repetition impossible.

These reasons must suffice to explain the departure from what we hold to be a useful precedent. There are, however, a few facts which should be emphasized in our last issue of 1914. In the early days of the existence of the "Medical Journal of Australia," the services of some of the most capable men in the Commonwealth had been secured to look after its interests in the various States. Almost every one of these men have volunteered for service with the Australian Expeditionary Forces, and are now attached to the various hospitals or regiments as medical officers. The country is lucky to have secured the services of these men, and we are convinced that their capability, kindness and knowledge will receive full recognition wherever they may go. We have been fortunate in obtaining representatives of marked competence to fill their places, but it must be pointed out that the conditions under which these men are working must make it extremely difficult for them to devote much time to this form of work. In addition to our valued collaborators, many other eminent practitioners have left this country with the medical units of the Expeditionary Forces, and the sacrifice which the medical profession has made in this direction is unlikely to find a parallel in any other body of citizens. The British Medical Association has determined without dissention to meet the increased amount of want and the

suffering due to unemployment, temporary loss of the breadwinner and increase of the price of necessities by extending a helping hand to those who cannot help themselves. This record at least is a pleasant one to make, and one which is worthy of the great profession of medicine.

ANOMALIES OF COLOUR VISION.

The subjective sense of colour vision is difficult, if not impossible, to define. An ordinary individual recognizes certain fields in the spectrum as definite colours, and names them in accordance with usage, although it is unknown whether the impression made by red is the same on any two individuals. Certain persons do not recognize each of the seven spectral colours as defined colours, and under all conditions name red green or green red. Again, persons are met with on rare occasions who cannot distinguish between any of the colours. Between this form of total colour blindness and what is regarded as perfect colour vision, is an endless series of anomalies of colour vision, some of which may be regarded as slight deviations from an arbitary normal, while others are definite defects. Some years ago, Edridge Green sought to classify colour distinction by determining the number of separate colour fields distinguished in the spectrum, and according to the number defined and named, he spoke of heptachromes, hexachomes, pentachromes, tetrachromes, trichromes, dichromes and monochromes. This classification has but a slight practical value, inasmuch as hepta- and hexachromic persons may vary very considerably in regard to the number of colour fields recognized, and, further, a tetrachromic person might conceivably be possessed of a colour vision which should be regarded as a variation of the normal, or he might be dangerously colour blind. Nevertheless, this measurement of colour vision conveys a good idea of what the forms of colour vision anomalies really are. At the same time, it suggests that the perception and recognition of colours is a psychic and not a visual phenomenon, and just as but few persons can be regarded as having a perfectly developed mental function, and only when the departure from the ideal standard of normal is very considerable can the individual be regarded as being mentally abnormal or insane, so but few presumably can divide the spectrum into a maximal number of differentiable fields, and a considerable departure from the theoretical standard is necessary before the condition is spoken of as colour blindness. Dr. Taylor, in a brief, but exquisitely suggestive contribution, published in the "Medical Journal of Australia" last week, indicated the apparent association between colour blindness and a negative psychic quality. That colour blind persons do not stammer does not necessarily mean that colour blind persons are mentally normal, but rather that whatever defects of mentality are prone to occur together the defect of colour perception, they are of a type wholly different from those leading to a loss of control of fluent speech. The philosophic observations of a scientist who is constantly examining the quality of colour perception and the visual acuity of men in varying classes of life and of varying degrees of intellectual development, are worthy of careful consideration. Dr. Taylor should have much more to tell us in regard to the mental, nervous and somatic attributes of colour defectives. We hope that he will tell us all he knows.

MEDICAL PRACTITIONERS AND UNQUALIFIED DENTISTS.

Medical practitioners in practice in the Commonwealth are apt to forget that while the regulations framed by the General Medical Council of Great Britain and Ireland do not directly affect the position of persons registered by the Australasian Medical Boards, many of them may do so indirectly. It is therefore well to remind the members of the medical profession in Australia of the fact that the Medical Boards have power to take steps under given circumstances to enforce the recognition of some of the resolutions of the General Medical Council, and to enquire into cases of infringement of the regulations which may be brought to their notice. One of the regulations which should be borne in mind reads as follows:—

> "Any Registered Medical Practitioner who knowingly and wilfully assists a person who is not registered as a dentist in performing any operation in dental surgery, either by administering anæsthetics or otherwise, will be liable, on proof of the facts, to be dealt with by the General Medical Council as having been guilty of infamous conduct in a professional respect."

We would point out that the General Medical Council may remove the name of a medical practitioner practising in Australia from the Register, and can bring the facts of the case to the knowledge of

the corporation or other body which has granted a diploma to the offender, with a view of having the diploma cancelled. The cancelling of the diploma on which a practitioner has become registered in Australia is cause for the removal of the name from the Australian Registers. In addition, the Medical Boards have the support of the Dental Boards in the endeavour to check practitioners from practising when they have been found guilty of "infamous conduct in a professional respect."

INFANTILE PARALYSIS IN BRISBANE.

The Department of Public Health reports that the incidence of epidemic anterior polio-myelitis in Brisbane is decreasing. In the week ending December 5, 15 cases were notified, as compared with 28 in the previous week. The Department has published another pamphlet, giving information to the public in regard to this disease. The etiology is receiving the close attention of the Acting Commissioner for Public Health, and, together with the various medical officers of health, he is investigating all the possible sources of infection in the cases notified. So far, it would appear that no definite discovery of the means of spread has been made. In the meanwhile, the "Brisbane Courier" publishes letters from lay persons, from which two facts transpire clearly. The first is that one section of the public is seeking knowledge, and another (which does not possess the knowledge) is pretending to supply the sought-for information. The second fact is that the public scare is likely to hamper the health authorities in their endeavours to cope with the matter. We learn with surprise that a gentleman who signs himself "Herbalist" had experience of a more serious epidemic 20 years ago, although, in those days, the fact that infantile paralysis is an infective disease was unknown, and no one dreamed of its occurrence in an epidemic form then.

AN OBSCURE EPIDEMIC.

For several weeks past the Department of Public Health at Auckland, New Zealand, has been concerned with an epidemic of an illness characterized by symptoms of intestinal intoxication. The number of persons affected in Onehunga and Ellerslie is stated to be between 300 and 400. It appears that the symptoms of vomiting, abdominal pain, cramps, and diarrhœa have been more prevalent among adults than children, and an investigation by Dr. Mackgill, the Medical Officer of Health, has demonstrated that the virus is not contained in milk, but is conveyed in all probability in water. The districts affected derive their water from a common source. The nature of the organism has not yet been disclosed, but it is announced that a full report on the investigations will be published within a short time. From the accounts which have appeared in the public press, it would appear as if the epidemic were caused by a bacillus of the Gaertner type of organism. Similar epidemics have been observed in other places, and, as a rule, can be controlled within a short time without much difficulty.

British Medical Association News.

SCIENTIFIC.

A meeting of the Eye and Ear Section of the Victorian Branch was held at the Eye and Ear Hospital, Melbourne, on November 24, 1914, Mr. Edward Ryan (the President) in the chair.

It was resolved that a letter be sent to Dr. James Jackson, for many years the Senior Oculist in Melbourne, expressing the high esteem in which he is held by his colleagues.

Mr. Edward Ryan demonstrated a case of tumour of the orbit. He stated that this case was a very puzzling one. The patient gave a history of twelve months' duration of the tumour. There had been no pain. The proptosed eye was displaced downwards, outwards, and forward. The vision had not suffered, and the fundus was apparently normal. He was inclined to regard the tumour as a mucocele.

Mr. Kent Hughes did not agree with this diagnosis, because he considered that a tumour in the frontal sinus or ethmoidal cells would not be likely to extend into the orbit. He favoured the diagnosis of a fibro-cystic tumour of the optic nerve.

Mr. Edward Gault expressed the opinion that the tumour was probably a mucocele. His experience taught him that these tumours contained mucus. In this instance it would appear as if the tumour was an infundibular mucocele. He suggested that it should be drained through the nasal route.

Mr. Edward Ryan also showed a case of symblepharon, which had been operated on.

Mr. Edward Gault demonstrated a case of tumour of the caruncle, which he said was quite unlike anything he had ever seen before. The tumour had been noticed for three months, and was now of the size of a haricot bean. He suspected that it might be sarcomatous, and hesitated between dealing with it operatively and applying radium.

Dr. N. E. Gibbs stated that the surface was broken, but admitted that this might have been due to the examination of the growth by the members of the section.

Mr. Edward Ryan held that exposure frequently caused thickening like that present in this case, and was of opinion that the growth was either a rodent ulcer or an epithelioma.

Several members suggested that a microscopical examination of a portion of the tumour should be made before any treatment was undertaken.

The following persons have been elected members of the New South Wales Branch:—

Dr. T. A. Daly, Concord.
Dr. John T. P. Tansey, College Street, Sydney.
Dr. Amos W. Bowman, Germanton.

ANNUAL MEETING.

The Annual Meeting of the Queensland Branch was held in the B.M.A. Rooms, Brisbane, on December 11, 1914.

The following members were elected for office for 1915:—

President, Dr. Brockway.
Vice-Presidents, Dr. Robertson, Dr. D. A. Cameron.
Hon. Secretary, Dr. Douglas.
Hon. Treasurer, Dr. Buchanan.
Librarian, Dr. McKenna.
Curator of Museum, Dr. Love.
Members of the Council, Dr. Meek, Dr. Carvosso, Dr. Kerr Scott, Dr. Hopkins.
Auditors, Dr. Bourne, Dr. Croll.

THE BRITISH MEDICAL ASSOCIATION (AUSTRALIA) MOTOR AMBULANCE FUND.

According to a statement published in the "New Zealand Herald" of December 12, 1914, the Hawke's Bay Division of the British Medical Association has responded most generously to an appeal made for providing motor ambulances. The amount subscribed had reached £1000, and subscriptions were still coming in. One ambulance had

already been ordered, and the hope is expressed that the division will be able to offer three to the Medical Service Department.

Since the Federal Committee issued a second circular letter to the members, and since we called the attention of our readers to the disappointing response to the appeal, the number of subscriptions has increased. We are pleased to state that the seventh list, which we print below, contains 71 names, and represents £107 5s. 6d. in fresh subscriptions, bringing the total up to £1065 12s.

	£	s.	d.
Dr. Abbott, G. H., Sydney	5	5	0
„ Ashton, T. B., Unley, S.A.	1	1	6
„ Avery, G., Roma, Q.	1	1	0
„ Barber, R. C., Essendon, Vic.	1	0	0
„ Bell, R., Sydney	1	1	0
„ Benjamin, A., Casino, N.S.W.	0	10	6
„ Bickle, L., Adelaide	1	1	0
„ Bignell, F. L., Lismore, N.S.W.	1	1	0
„ Boyes, W., Wangaratta, Vic.	3	3	0
„ Broadbent, P. F., Forbes, N.S.W.	2	2	0
„ Browne, A. E. N., Sydney	1	1	0
„ Cole, F. H., Carlton, Vic.	1	2	0
„ Connor, S., Coleraine, Vic.	0	10	6
„ Cook, Sydney, Ulmarra, N.S.W.	1	1	0
„ Cooley, P. G., Redfern, N.S.W.	1	1	0
„ Crago, W. H., Sydney	1	1	0
„ Craig, R. Gordon, Sydney	5	5	0
„ Cuscaden, G., Melbourne	1	1	0
„ Dansey, St. J., Strathfield, N.S.W.	1	1	0
„ Davidson, G., Sandgate, Q.	1	1	6
„ Docker, E., Trangie, N.S.W.	1	1	0
„ Drew, C. T., Kadina, S.A.	1	1	0
„ Duhig, J. V., Bundarra, N.S.W.	0	10	6
„ Furber, R., Enmore, N.S.W.	1	1	0
„ Gilchrist, J. J., East Kempsey, N.S.W.	1	1	6
„ Giles, W. Anstey, Adelaide	2	2	0
„ Good, R. S., Young, N.S.W.	0	10	6
„ Halcomb, C. D., Lindfield, N.S.W.	1	1	0
„ Harris, H. L., Tamworth, N.S.W.	1	1	6
„ Harbison, J. A., Numurkah, Vic.	1	1	0
„ Harvison, W. S., Cooma, N.S.W.	1	1	0
„ Hill, R. H., Tocumwal, N.S.W.	1	1	0
„ Hogg, G. H., Launceston	1	1	0
„ Hughes, L. H., Cessnock, N.S.W.	0	10	6
„ Kelly, J. J., Sydney	2	2	0
„ Kelly, W. R., Charters Towers, Q.	2	2	0
„ Laurie, Hy., St. Kilda, Vic.	1	2	0
„ Lyttle, S., West Wyalong, N.S.W.	1	1	0
„ Macarthur, J., Crookwell, N.S.W.	1	1	0
„ Maclean, L. A., Thirlmere, N.S.W.	1	1	0
„ MacMaster, D., Sydney	2	2	0
„ Martin, Harold, Sydney	1	1	0
„ Morton, W. J., Inverell, N.S.W.	1	1	0
„ McKell, T., Barraba, N.S.W.	1	1	0
„ O'Hallaron, C. M., Tingha, N.S.W.	1	1	0
„ O'Reilly, M., Bega, N.S.W.	1	1	0
„ Palmer, C. R., Bulli, N.S.W.	1	1	0
„ Parramore, G. D., Nabiac, N.S.W.	1	1	0
„ Patterson, M., Ipswich, Q.	2	2	0
„ Paul, James W., Gosford, N.S.W.	1	1	0
„ Peet, H., Gilgandra, N.S.W.	1	1	0
„ Pirie, J., Liverpool, N.S.W.	1	1	0
„ Ponsford, F. W. A., Delegate, N.S.W.	1	1	0
„ President, Queensland Branch, B.M.A.	10	10	0
„ Roberts, L. W., Orange, N.S.W.	1	1	0
„ Roseby, E. R., Delungra, N.S.W.	0	10	6
„ Scott, V. S., Malvern, Vic.	1	1	0
„ Sear, H. R., Sydney	2	2	0
„ Skirving, R. Scot, Sydney	2	2	0
„ Stevenson, F. C., Moss Vale, N.S.W.	2	2	6
„ Thomas, D., Manly, N.S.W.	5	5	0
„ Thomas, E. B., Maitland, S.A.	1	0	0
„ Turner, T. H., Merriwa, N.S.W.	1	1	0
„ Veech, M., Sydney	1	1	0
„ Vickers, W., Drummoyne, N.S.W.	1	1	0
„ Wall, A. P., Randwick, N.S.W.	1	1	0
„ Wallace, D., Sydney	2	2	0
„ Walton, W. B., Homebush, N.S.W.	1	1	0
„ Whiting, Keith, Parramatta, N.S.W.	2	2	0
„ Wilson, C. E. C., Kadina, S.A.	1	2	0
„ Wrigley, W., Glen Innes	1	1	0

Public Health.

SMALL-POX IN SYDNEY.

The number of small-pox cases reported to the Department of Public Health, New South Wales, during the week ended December 20, 1914, was:—

	Cases.
City of Sydney and Metropolitan District	2
Country (Penrith)	1
Total	3

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received from the Department of Public Health, Queensland, during the week ended December 12, 1914:—

Notifiable Disease.	Cases.
Enteric Fever	42
Diphtheria	24
Varicella	6
Phthisis	6
Erysipelas	3
Scarlet Fever	2
Infantile Paralysis	18
Total	101

The number of cases of infantile paralysis reported in the State has varied considerably during the past few weeks. In the week ending November 21 it was 3, in the week ending November 28 it was 34, while in each of the weeks ending December 5 and 12 it was 18. It must, however, be borne in mind that some of the cases reported may have been of a different nature, and, according to the views expressed by some of the Medical Officers of Health, this was probably the case.

THE HEALTH OF VICTORIA.

During the fortnight ended December 8, 1914, the following returns have been received from the Department of Public Health, Victoria:—

	Enteric Fever.		Diphtheria.		Scarlet Fever.		Pulmonary Tuberculosis.	
	Whole State.	M'tropolit'n.	Whole State.	M'tropolit'n.	Whole State.	M'tropolit'n.	Whole State.	M'tropolit'n.
Cases	43	9	138	73	20	12	96	70
Deaths	2	1	1	—	—	—	18	16

The number of cases of enteric fever and diphtheria notified from the various municipalities for the fortnight ended December 8, 1914, were as follows:—

Municipality.	Enteric Fever.	Diphtheria.
Bendigo	—	14
Prahran	—	7
Richmond	—	7
Swan Hill	4	—

Enteric fever is rather more prevalent than usual at this time of year, but the cases are scattered all over the State; no localized outbreak.

THE HEALTH OF AUCKLAND.

The following cases of infective diseases were notified during the month of November to the District Medical Officer of the Auckland District:—

	City of Auckland.	Suburban Districts.	Country Districts.	Total.
Scarlatina	2	2	5	9
Diphtheria	6	6	20	32
Enteric Fever	—	2	28	30
Tuberculosis	5	5	12	22
Varicella	3	11	18	32
Cerebro-spinal Meningitis	—	—	3	3

One case of blood poisoning was recorded in the country districts.

INFECTIVE DISEASES IN WESTERN AUSTRALIA.

The notifications received by the Department of Public Health, Western Australia, for the week ending November 21, 1914, were:—

	Enteric Fever.	Diphtheria.	Phthisis.
Leederville	2	1	—
Perth	3	1	1
Mt. Lawley	—	2	1
Claremont	—	—	3
Midland Junction	1	1	—
Victoria Park	2	—	—
Kalgoorlie	3	—	1
Kalgoorlie Road District	1	—	—
Boulder	1	1	—
Bunbury	—	1	—
Yilliminning	1	—	—
Collie	2	—	—
Menzies	1	—	—
	—	—	—
Totals	17	7	6

The notifications received by the Department of Public Health, Western Australia, for the week ended November 28, 1914, were:—

	Enteric Fever.	Diphtheria.	Phthisis.	Erysipelas.
Fremantle	—	—	2	—
Subiaco	1	3	—	—
Leederville	2	—	—	—
Perth	—	4	3	1
Midland Jntn.	—	2	—	—
Canning Mills	—	1	—	—
Kalgoorlie	1	—	1	—
Boulder	—	1	1	—
Coolgardie	—	1	—	—
Laverton	—	—	1	—
Katanning	—	—	1	—
Collie	—	3	—	—
Beverley	1	—	—	—
Victoria Park	1	—	—	—
Meekatharra	2	—	—	—
	—	—	—	—
Total	8	15	9	1

University Intelligence.

UNIVERSITY OF WESTERN AUSTRALIA.

The election of Dr. Roberta Jull to the Senate of the Western Australian University was determined on by Convocation on December 8, 1914. The National Council of Women had pressed for the acceptance of the principle that there should be two women members of the Senate. As a result of this action, Dr. Jull had been appointed.

A new method of election is to be utilized in connexion with the Convocation of members of the Senate. This method, which is by preferential voting, has been worked out by Dr. Nanson, of the Melbourne University. It appears to be a modification of the single transferable vote system of proportional representation, and as far as we are able to judge does not possess any material advantage over the latter.

SYDNEY UNIVERSITY.

At a meeting of the Senate of the University of Sydney, held on December 14, 1914, it was decided that a Chief Executive Officer of the University shall be appointed, and that this officer shall be an ex-officio member of all the faculties, boards and committees. The by-laws have been so amended as to enable this to be done. The present Registrar, Mr. H. E. Barff, was thereupon appointed to the new office, and it was determined that his title should be Warden and Registrar. His duties are defined as follows:—(a) To attend all meetings of the Senate and its Committees, and to advise the Senate of all matters of University administration; (b) to consult with and advise the Professorial Board and all other University Boards, faculties, committees, professors, and other heads of the departments, with a view to the more efficient co-ordination of the work of the faculties and their various departments; (c) to collect and prepare for the Senate and the Finance Committee all the information, including estimates of receipts and expenditure required by them in relation to the finances of the University; (d) to exercise a general supervision over the discipline of the University; and (e) to perform such other duties as may from time to time be assigned to him.

Correspondence.

THE ENTERIC FEVER PROBLEM.

Sir,—I read with pleasure your article in your last issue of this journal on "Prevention of Enteric Fever," and I would ask space to explain an erroneous construction put on a portion of my letter, where I am given credit for the following views: "He speaks of the removal of the cause, which, in his opinion, is the house fly." My letter does not contain such a statement; on the contrary, it states: "The old rule 'remove the cause,' i.e., pollution of food, etc., with fæcal matter, matter borne by contaminated flies," again, "and instead of removing the main cause of typhoid and gastro-enteritis, those places **where flies can contaminate themselves by contact with human excreta,** by making them fly proof, we now have a proposal to render our population immune to living in filthy surroundings as far as enteric is concerned, taking no notice of gastro-enteritis or the repulsive fact that fæcal contaminated flies are allowed to pollute our food."

Of course, the contamination above referred to must contain Eberth's bacillus to cause enteric, and I had better call the contaminated fly as the essential factor in dissemination. The position to-day is so bad that if one were to devise a plan to disseminate enteric we would have to admit that present conditions fulfil all modern requirements (would be termed ideal, I suppose).

A. Incubator.—Pan kept at suitable temperature by summer heat.

B. Nutrent Media.—Putrescent animal matter.

C. Specific Virus (Eberth's bacillus).—Provided by convalescent and typhoid carriers.

D. Disseminator.—House fly (1) inoculates all adjoining pans it visits with specific virus; (2) carriers specific virus from the infested excreta to the victim's food.

The fact that a municipality and a shire has earned the goodwill of the residents by wiping away the unenviable reputation of their being fever-stricken is fair ground for asking that other municipalities and shires should be made to toe the line by doing as well or better, and wipe away the reproach which has hung over the sanitation of the country. Why wait for the Commonwealth to appoint medical officers of health for the country when the States have the power, but have practically only exercised it for metropolitan areas?

Yours truly,

HENRY STOKER, F.R.C.S.I., D.P.H.

Wagga Wagga, December 19, 1914.

Obituary.

EDWARD SEYMOUR-BRETT.

It is with regret that we record the death of Dr. E. Seymour-Brett, of Strahan, Tasmania. Dr. Seymour-Brett was only 37 years of age. He was just about to leave Tasmania, having sold his practice to Dr. Graham, of Melbourne. He served his country with distinction during the Boer war, and was decorated with a medal and four clasps. Dr. Seymour-Brett was a graduate of the Edinburgh University, and obtained the degree of B.Sc. (Public Health) in 1904. He studied anatomy under Professor Berry, at Melbourne, and was regarded as one of the most proficient students of his year. For some time past Dr. Seymour-Brett had been suffering from rheumatic arthritis with endocardial complication, and he died suddenly on September 19, 1914, from heart failure. He leave a widow and a little son, aged 7 months.

Proceedings of Australasian Medical Boards.

SOUTH AUSTRALIA.

The following person has been registered under the conditions of "The Medical Act, 1880," as a qualified medical practitioner:—

Robert Fulton Craig, M.B., B.S. (Melb.), 1911.

—o—

Medical Appointments.

Dr. J. Walker has been appointed Medical Officer of Health at Kalgoorlie, W.A., in place of Dr. J. C. McMillam.

Dr. F. W. Stone has been appointed Acting District Medical Officer and Public Vaccinator at Katanning, Western Australia, during the absence on leave of Dr. F. M. House.

We learn that Dr. Thomas Goddard, at present assistant to Dr. Cameron at the Mount Bischoff Provident Hospital, Waratah, Tasmania, has been appointed Junior House Surgeon at the Hobart General Hospital.

The following appointments have been made at the Perth Public Hospital:—

Dr. L. M. Piggott, Junior Resident Medical Officer.

Dr. Watch, Honorary Physician to the Infectious Diseases Branch Hospital at West Subiaco.

—o—

Medical Appointments Vacant.

CHILDREN'S HOSPITAL INCORPORATED, PERTH.

APPLICATIONS are invited for the position of CHIEF RESIDENT MEDICAL OFFICER; salary £300 with board, lodging and laundry. Term: one year, with option of renewal; children's experience essential. Registration paid, and £10 10s. towards travelling expenses. Applications to reach General Secretary by 12th January, 1915.

C. J. KILLICK,
General Secretary.

New South Wales Public Service Board,
4 O'Connell Street, Sydney,
December 5, 1924.

APPLICATIONS are invited for the position of MEDICAL OFFICER (Female), Medical Branch, Department of Public Instruction, Professional Division. Salary, £400 per annum and travelling expenses. Dutes will be mainly limited to districts near the large country towns. Application should reach the undersigned not later than 11th January, 1915. In terms of the Public Service Act, suitable applicants already permanently employed in the Public Service will receive first consideration in the filling of permanent positions.

By order of the Board.
R. A. GILFILLAN, Secretary.

Part-time ASSISTANT required for the "Medical Journal of Australia," Medical man preferred. Excellent opportunity for young man desiring to learn journalism. Hours of attendance to be arranged.

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—o—

Books Received.

IMMUNITY: METHODS OF DIAGNOSIS AND THERAPY AND THEIR PRACTICAL APPLICATION. Dr. Julius Citron, translated from the German and Edited by A. L. Garbat, M.D. Second Edition, revised and enlarged. 1914. Philadelphia: P. Blakiston's Son & Co. (Angus & Robertson). Demi 8vo., pp. 267. Price 15s.

THE DIAGNOSIS AND TREATMENT OF DIGESTIVE DISEASES: A PRACTICAL TREATISE FOR STUDENTS AND PRACTITIONERS OF MEDICINE, by George M. Niles, M.D. 1914. Philadelphia: P. Blakiston's Son & Co. (Angus & Robertson). Royal 8vo., illustrated pp. 595. Price 21s.

—o—

Diary for the Month.

Jan. 5.—New South Wales Branch B.M.A., Council Meeting.

Jan. 12.—New South Wales Branch B.M.A., Council Meeting.

Jan. 15.—Eastern Medical Association, New South Wales, annual meeting.

Jan. 20.—Western Australian Branch, B.M.A., Branch Meeting.

Jan. 26.—New South Wales Branch B.M.A., Committee Meetings.

Jan. 27.—Victorian Branch B.M.A., Council Meeting.

—o—

Important Notice.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
QUEENSLAND. (Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane).	Brisbane United F.S. Institute. F.S. Lodges at Longreach. F.S. Lodges at Warwick.
WESTERN AUSTRALIA. (Hon. Sec. 230 St. George's Terrace, Perth).	Swan District Medical Officer. All Contract Practice Appointments in W.A.
NEW SOUTH WALES. (Hon. Sec. 30-34 Elizabeth Street, Sydney).	Australian Natives Association. Balmain United F.S. Dispensary. Burwood District F.S. Institute. Carrington Lodge, No. 75, P.A.F.S. of A., Randwick. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows Med. Inst., Elizabeth Street, Sydney. N.S.W. Ambulance Association and Transport Brigade. N. Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Braidwood. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Mudgee. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Granville, Penrith and Auburn. Killingworth Colliery, Newcastle. Seaham Colliery No. 1, Newcastle. Seaham Colliery No. 2, Newcastle. West Wallsend Colliery, Wallsend.
SOUTH AUSTRALIA. (Hon. Sec. 3 North Terrace, Adelaide).	The F.S. Medical Assoc. Incorp., Adelaide.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to the "Medical Journal of Australia" alone, unless the contrary be stated.

All communications should be addressed to "The Editor," "Medical Journal of Australia," B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.

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With which is incorporated "The Australasian Medical Gazette," and "The Australian Medical Journal.")

The Journal of the Australian Branches of the British Medical Association.

VOL. I.—No. 26. SYDNEY: SATURDAY, DECEMBER 26, 1914. PRICE 6D.

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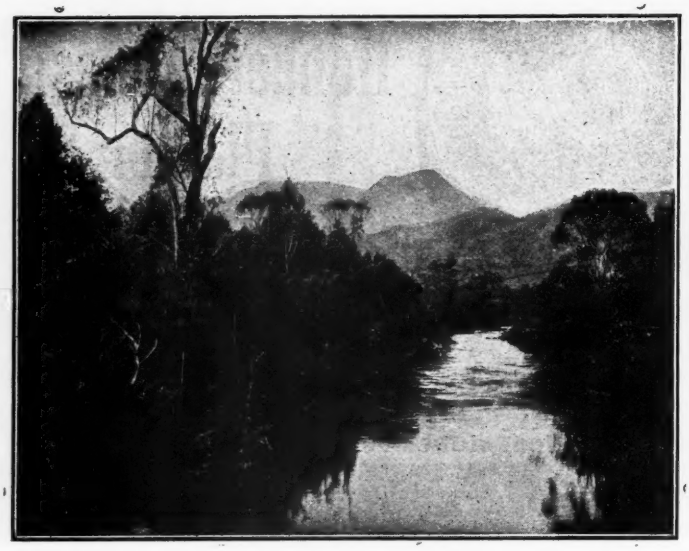

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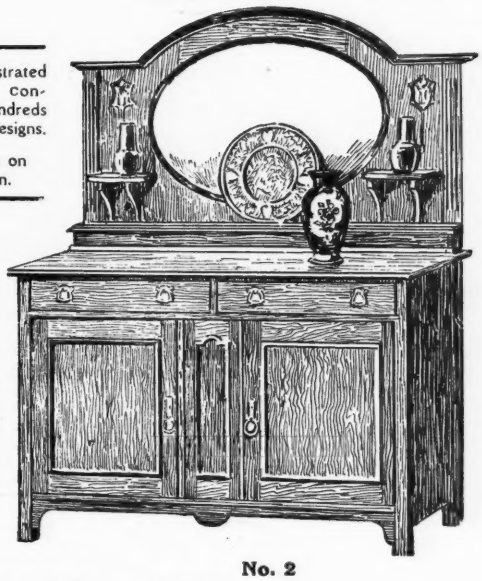

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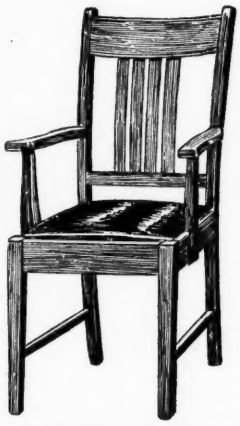

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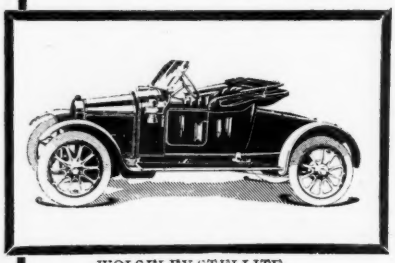

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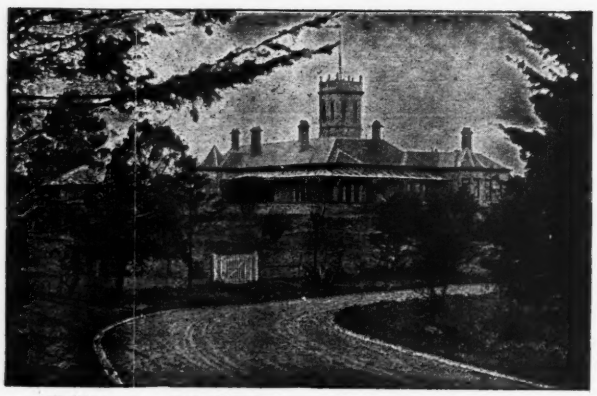

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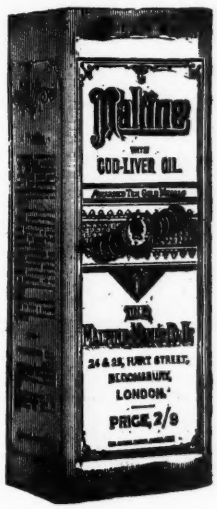

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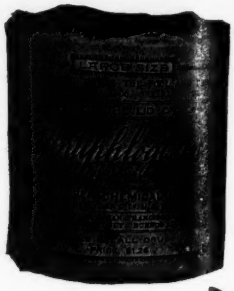

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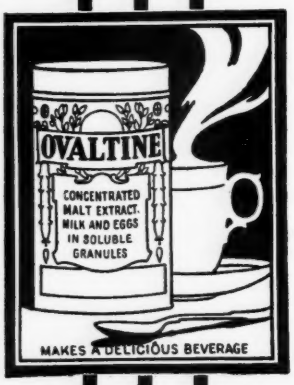

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